Improving the Value of Medical Care

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Background

Conventional Issues
- Access
- Cost
- Quality

Real Issues
- Access
- Value

Spending money isn't bad. Wasting money is.

An Assessment of Value

Is Done		Should Be Done: Yes	Should Be Done: No
	Yes	+	Acute
	No	Chronic	+

Where is there money to be saved?

- Insurance premiums: administrative cost
  - Average is 15%; could cut by 2/3
  - Solution: group small firms into large pools.
- Care receipt: overused care
  - About 25-30 percent of care is not needed
- Care provision: Lots of inefficiency within institutions
- *As much as 50% of medical care might be wasteful – up to $1 trillion of benefit if we get it right*

Insurance Administration

- Nearly $100 billion is spent on private insurance administration (14% of PHI)
  - Federal gov't spends $26 bn (4% of Federal health spending)
- Big issue: eliminating individual/small group risk rating.
  - Community rating
  - Purchasing pools

Examples of Overused Care

- Medical care in the US vs. …
- Medical care in Massachusetts vs. …
- Wennberg et al.: Bringing Medicare spending to the level of the 25%ile would save 25-30%.

Examples of Underused Care

- Chronic disease control is no better than 1 in 3.
- People find system confusing to use.
- Use of IT is extremely low.

Options

Global caps	Demand-side	Supply-side
Fixed amt of $$$; Technology caps; Tight fee limits	Increased cost sharing	Pay-for-performance; Health IT
It's what other countries do	Consumers will drive efficiency improvement	Provider incentives are key

All rely on a strong information base: price and quality information provided to consumers

What Do We Know? Demand Side

- Use is sensitive to patient cost sharing
  - Moving to catastrophic coverage might save 25% (???), $300 billion.
- Problems:
  - Will patients give up care that is valuable?
    - The statin example
  - Will this lead to adverse selection?

What Do We Know? Supply-Side

- Each has potential
  - Rand: HIT could save $77 bn / year
  - Prices influence what is done
  - Actual evidence is limited (hard to test it on a small scale)
- Problems:
  - Up front costs ($150 bn for HIT)
  - Potential adverse incentives (gaming the system)
  - Uncooperative MDs (get MDs to design)

Collective Action is Key

- Set ambitious quality/cost goals
  - Eliminate errors, reduce paperwork, lower cost relative to trend, etc.
- Measure cost and quality outcomes
- Commit to supply-side reforms
  - Performance-based payment
  - Health IT financing (loans, grants, conditioned payments)

Example – Eastern Massachusetts Healthcare Initiative

- Goals
  - Eliminate hospital-acquired infection
  - Analyze variation in care
  - Develop a plan for interoperable IT
- Timeframe
  - Make significant progress in 1st year
- Funding
  - From institutions

The Challenge

Some area has to be the leader in the 21st century health care system. Which area will it be?